

## MARYLAND STATE DEPARTMENT OF HEALTH

3804

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

T

VS. A15

1. PLACE OF DEATH: COUNTY Harford		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN Belvoir		LENGTH OF STAY (in this place) 7 months	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Walter's Nursing Home		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 706 Market Street	
		STREET Harry de Gruy (give alternative location) ADDRESS Anna, Maryland	
3. NAME OF DECEASED (Type or Print)	(First) Margaret	(Middle) Rebecca	(Last) Abt
4. SEX Female	5. COLOR OR RACE White	6. MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	7. DATE OF BIRTH July 1867
8. AGE last birthday 11 yrs.	9. If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House keeper	10b. KIND OF BUSINESS OR INDUSTRY Employee	11. BIRTHPLACE (State or foreign country) Harford County, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George W. Lear	14. MOTHER'S MAIDEN NAME Mary Katherine Shay		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Mr. James B. Lear	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Ch. Myocardial Disease*

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

(b) \_\_\_\_\_

(c) \_\_\_\_\_

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN  
ONSET AND DEATH

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from April 29, 1951, to April 29, 1951, that I last saw the deceasedalive on April 29, 1951, and that death occurred at 5:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE May 2, 1951	NAME OF CEMETERY OR CREMATORIAL Spesutia Cemetery	LOCATION (City, town, or county) Harford County, Md.	(State)
DATE REC'D BY LOCAL REG. 5/1/51	REGISTRAR'S SIGNATURE Virginia L. Taword	24. FUNERAL DIRECTOR ADDRESS Howard Mitchell Lavende Grace, Md. 720636		

**RECEIVED**

MAY 4 1951

BUREAU V. S.

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

3805

Reg. Dist. No. 182

1. PLACE OF DEATH: COUNTY <i>Harford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>	
TOWN <i>Marlinton</i>		TOWN <i>Marlinton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET (If rural, give location) <i>Marlinton</i>	
3. NAME OF DECEASED (Type or Print) <i>Gertrude Irene Aikens</i>		4. DATE OF DEATH <i>April 22 1951</i>	
5. SEX <i>Female Colored</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Single</i>	8. DATE OF BIRTH <i>March 10 1951</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Aikens</i>		14. MOTHER'S MAIDEN NAME <i>Gertrude Aikens</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Mo</i>	
17. INFORMANT <i>Joseph Aikens</i>		18. MEDICAL CERTIFICATION <i>Marlinton, Md.</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>—</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  916.0 Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 180 (c)			
(a) <i>Third degree burns face</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>—</i>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>April 22 1951 11A.m.</i>		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY <i>Home</i> White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <i>Burned in house fire</i>	
(CITY OR TOWN) <i>Darlington</i>		(COUNTY) <i>Harford</i>	
(STATE) <i>Md</i>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>Gerold C Palmer MD</i>		ADDRESS <i>200 Medical Fairstreet Harford Co. Md April 22 1951</i>	
DATE SIGNED			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>April 24 1951</i>	
DATE RECED BY LOCAL REG. REC'D.		NAME OF CEMETERY OR Crematory <i>Green Spring Cem. Harford Co. Md</i>	
REG. REC'D.		LOCATION (City, town, or county) <i>Harford Co. Md</i>	
REG. REC'D.		(State)	
REG. REC'D.		24. FUNERAL DIRECTOR <i>C. H. Clark H. S. Bailey, Marlinton, Md.</i>	
REG. REC'D.		ADDRESS	

RECEIVED  
MAY 4 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3806

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <i>Harford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Arlington</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Arlington</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Samuel</i>	(Middle) <i>G</i>	(Last) <i>Bishop</i>
4. DATE OF DEATH <i>April 15, 1957</i>	(Month)	(Day)	(Year)
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>June 4/87 1879</i>
9. AGE last birthday yrs. <i>79</i>	If under 1 year Months	If under 24 hrs. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired dairy farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Grayson Co., Va.</i>
12. CITIZEN OF WHAT COUNTRY <i>USA</i>		13. FATHER'S NAME <i>Samuel Bishop</i>	
14. MOTHER'S MAIDEN NAME <i>Arthur Bishop</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>Mr</i>		17. INFORMANT AND ADDRESS <i>Arthur Bishop, Arlington, Md.</i>	
18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>2 hr.</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) <i>Acute pulmonary Edema due to Acute Congestion</i></p> <p>Antecedent cause(s) (b) <i>Cardiac failure due to generalized arterio-sclerotic and old age</i></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Sclerosis and old age</i></p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 1, 1950</i> , to <i>April 15, 1951</i> , that I last saw the deceased alive on <i>April 15, 1951</i> , and that death occurred at <i>2:30 p.m.</i> from the causes and on the date stated above. SIGNATURE (Degree or title) <i>Malcolm Dudley</i> ADDRESS <i>Arlington, Md.</i> DATE SIGNED <i>4/16/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF NAME OF CEMETERY OR Crematory LOCATION (City, town or county) <i>April 17, 1951</i> <i>Arlington Cem.</i> <i>Harford Co., Md.</i> (State)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE <i>C. J. Kirk</i>	
24. FUNERAL DIRECTOR ADDRESS <i>F. S. Bailey</i>			

RECEIVED

MAY 4 1961

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY <i>Harford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Aberdeen</i>		LENGTH OF STAY (In this place) <i>life</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Washington Street.</i>		STREET ADDRESS <i>Washington Street</i>	
3. NAME OF DECEASED (Type or Print) <i>Daniel J. Brown</i>	(First)      (Middle)      (Last)	4. DATE OF DEATH <i>4 20 1951</i>	(Month)      (Day)      (Year)
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>3-27-1879</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Day laborer on farm</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	9. AGE last birthday <i>72 yrs.</i>
13. FATHER'S NAME <i>Louis J. Brown</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mrs. Mirrie J. Brown</i>
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>Respiratory Failure</i>			
(a) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Cerebral Hemorrhage</i>			
(b) <i>Cerebral Arteriosclerosis</i>			
(c) <i>Arterosclerotic Heart Disease</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>—</i>			
19a. DATE OF OPERATION <i>None</i>	19b. MAJOR FINDINGS OF OPERATION <i>Arterosclerotic Heart Disease</i>	INTERVAL BETWEEN ONSET AND DEATH <i>Terminated 10 days 1 yr.</i>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

21. ACCIDENT SUICIDE HOMICIDE <i>No</i>	Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>Injury</i>	(CITY OR TOWN) <i>—</i>	(COUNTY) <i>—</i>	(STATE) <i>—</i>
--	----------	--	----------------------------	----------------------	---------------------

TIME (Month) (Day) (Year) (Hour) OF INJURY <i>— m.</i>	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
---	--	-----------------------

22. I hereby certify that I attended the deceased from alive on <i>4-11-1951</i> , and that death occurred at <i>12:05</i> m., from the causes and on the date stated above. SIGNATURE <i>W. Hodson Jr.</i> ADDRESS <i>—</i> DATE SIGNED <i>4-23-51</i>
---

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>4/23/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Union M. Cemetery Aberdeen Harford Co. Md.</i>	LOCATION (City, town, or county) (State) <i>—</i>
---	--------------------------------	--	---

DATE REC'D BY LOCAL REG. <i>April 23-1951</i>	REGISTRAR'S SIGNATURE <i>Nellie Z. Riley</i>	24. FUNERAL DIRECTOR <i>Henry Tarrington and Sons Aberdeen</i>	ADDRESS <i>820 105 Maryland</i>
--	---	---	------------------------------------

**RECEIVED**

APR 25 1951

BUREAU W. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3808

Reg. Dist. No.

185-

## CERTIFICATE OF DEATH

1. PLACE OF DEATH  
COUNTY

HARFORD

MARYLAND

CITY (If outside corporate limits, write RURAL and LENGTH OF STAY  
OR give nearest town) (In this place)

TOWN HAURE de GRACE 3 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS HARFORD MEMORIAL HOSP.3. NAME OF  
DECEASED  
(Type or Print)

Ralph

(Middle)

2. USUAL RESIDENCE (HOME) OF DECEASED  
STATE

Maryland

COUNTY

HARFORD

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR

TOWN HAURE de GRACE

(If rural, give location)

STREET  
ADDRESS

713 N. STOKES

4. DATE  
OF  
DEATH

April

12

1951

yrs.

Months

Days

Hours

Min.

## 5. SEX

Male

6. COLOR OR RACE  
White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED  
(Specify)

## 8. DATE OF BIRTH

Manuel unknown

## 9. AGE last birthday

at 70

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

laborer

10b. KIND OF BUSINESS OR  
INDUSTRY

Auto Dept. Harford

## 11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT  
COUNTRY

Italy

## 13. FATHER'S NAME

Unknown

## 14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)

No

## 16. SOCIAL SECURITY NO.

Unknown

## 17. INFORMANT AND ADDRESS

Mrs. Ralph Calicchia, Hanover Grace, Md.

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Hypertensive Cardiovascular  
disease.

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

## (Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY

## INJURY

## (CITY OR TOWN)

## (COUNTY)

## (STATE)

While at Work  Not While At work 

## HOW DID INJURY OCCUR?

## 22. I hereby certify that I attended the deceased from 4-9, 1951, to 4-12, 1951, that I last saw the deceased

alive on 4-12, 1951, and that death occurred at 1:30 A.M., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL/CREMATION  
REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORIUM

## LOCATION (City, town or county)

## (State)

## DATE REC'D BY LOCAL REGISTRY'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

REC'D April 14, 1951

A. L. Lewis M.D. Cunningham &amp; Son

Hanover Grace, Md.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3809

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY <i>Hanford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baldwin</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baldwin</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hanford Community Home</i>		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print)	First) <i>Laura</i>	(Middle) <i>Connelly</i>	(Last)
4. DATE OF DEATH <i>April 2</i>	(Month)	(Day)	(Year) <i>1951</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Dec 17-1863</i>
9. AGE last birthday yrs. <i>85</i>	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baldo - Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Baldo - Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>95</i>	
13. FATHER'S NAME <i>Nixon Connally</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Piddle</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>574-33-Connally</i>	
17. EMPLOYER AND ADDRESS <i>Holyd B Connally</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>Hypostatic Pneumonia, terminating</i>			
(a) <i>36 hr</i>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last <i>922.1</i>			
(b) <i>Ch. Cardio vascular Disease</i>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work m.	HOW DID INJURY OCCUR? Not While At work
22. I hereby certify that I attended the deceased from <i>Mar 28</i> , 1951, to <i>April 2</i> , 1951, that I last saw the deceased alive on <i>April 2</i> , 1951, and that death occurred at <i>10:15 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Willard P. Hudson, M.D.</i> ADDRESS <i>Forest Hill, Md</i> DATE SIGNED <i>4/3/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>Apr 5-51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Tunely LeFevre</i>
DATE REC'D BY LOCAL REG <i>4/4/51</i>		LOCATION (City, town, or county) <i>Long Green, Md</i>	(State)
REGISTRAR'S SIGNATURE <i>Francesca Lovwood</i>		M. FUNERAL DIRECTOR <i>C. L. Arthur Ford, Md</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3810

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Harford		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Havre de Grace Life		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR 620 Otsego Street STREET ADDRESS		STREET ADDRESS 620 Otsego Street (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Emma	(Middle) Jane	(Last) Currier
4. DATE OF DEATH	(Month) April	(Day) 29	(Year) 1951
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Widowed.	8. DATE OF BIRTH March 24, 1865
9. AGE last birthday 86 yrs.	If under 24 hrs. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Crawford		14. MOTHER'S MAIDEN NAME Carolyn Grant	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT AND ADDRESS Mrs. L. H. Eaton 620 Otsego Street		18. MEDICAL CERTIFICATION Havre de Grace, Md.	
INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 420.1		(a) Coronary Occlusion	
Antecedent cause(s) 93d		Chronic myocarditis	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1939, 19, to 4-29, 1951, that I last saw the deceased alive on 4-29, 1951, and that death occurred at 2 p.m. from the causes and on the date stated above. SIGNATURE			
ADDRESS DATE SIGNED <i>Albert Lewis and Havre de Grace, Md. Apr 30-51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE May 1, 1951	
NAME OF CEMETERY OR CREMATORIUM Angel Hill Cemetery		LOCATION (City, town, or county) Havre de Grace, Md.	
LOCATION (State)			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Apr. 30-1951 A. J. Lewis M.D.		24. FUNERAL DIRECTOR ADDRESS <i>H. Madison Mitchell</i>	



MAY 3 1951

LAUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

3811

Item #21 on:

**2411 N. Charles Street, Baltimore**

**CERTIFICATE OF DEATH**

Reg. Dist. No. .... 185 -

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
<i>Halford</i>		<i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Hare de Grace, me.</i>		TOWN <i>Hare de Grace, m.d.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <i>R D # 2</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>Susan</i>		(Month) <i>4</i>	
(Middle) <i>Amanda</i>		(Day) <i>15</i>	
(Last) <i>Curry</i>		(Year) <i>1951</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>Female</i>	<i>white</i>	<i>widowd</i>	<i>Nov. 28, 1870</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE last birthday	
<i>Nameless</i>		If under 1 year Months <i>80</i> yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		If under 24 hrs. Days <i>0</i> Hours <i>0</i> Min.	
<i>Retired Home</i>			
13. FATHER'S NAME		11. BIRTHPLACE (State or foreign country)	
<i>George Woodbury</i>		<i>Halford County, m.d.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY?	
		<i>U. S.</i>	
16. SOCIAL SECURITY NO.		14. MOTHER'S MAIDEN NAME	
<i>?</i>		<i>Susan Singleton</i>	
17. INFORMANT		<i>ms. Hubert Morris</i>	
		<i>Halford RD # 2</i>	

MARGIN RESERVED FOR BINDING

**PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause		(a) <u>Generalized Arteriosclerosis</u>			
Antecedent cause(s)		(b) <u>Father's Fracture, right</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?	
					Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) <u>accident</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Home</u>	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day) <u>26 March</u>	(Year) <u>51</u>	(Hour) While at Work <input type="checkbox"/> At work <input type="checkbox"/>	INJURY OCCURRED Not While Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>Fall from wheel chair as patient attempted to get up (4/26/51)</u>
22. I hereby certify that I attended the deceased from <u>4-72</u> , 19 <u>51</u> , to <u>4-15</u> , 19 <u>51</u> , that I last saw the deceased <u>alive on 4-14-51</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>John A. Sarow, M.D.</u>	(Degree or title) <u>Harford Memorial Hosp.</u>		ADDRESS <u>Harford Memorial Hosp.</u>	DATE SIGNED <u>4-15-57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April 18, 1951</u>	NAME OF CEMETERY OR CREMATORIAL <u>Harmony</u>	LOCATION (City, town, or county) <u>Harford County</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REGISTRAR	REG#	REGISTRAR'S SIGNATURE <u>A. Z. Lewis M.D.</u>	24. FUNERAL DIRECTOR	ADDRESS <u>H. Madison Mitchell</u>	
Date _____					



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3812

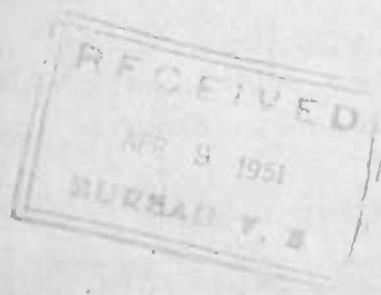
## CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <b>Harford</b>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Maryland</b> TOWN Havre de Grace		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Havre de Grace	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <b>II 18 St. Johns</b>	
3. NAME OF DECEASED (Type or Print) <b>Olivia Durbin</b>		(First) (Middle) (Last)	4. DATE OF DEATH <b>4/3/51</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <b>Married</b>	8. DATE OF BIRTH <b>6/9/1876</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	9. AGE last birthday If under 1 year Months Days Hours Min. <b>74 yrs. 9 22</b>
13. FATHER'S NAME <b>John Richardson</b>		11. BIRTHPLACE (State or foreign country) <b>Havre de Grace</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
17. INFORMANT AND ADDRESS <b>Joseph H. Durbin, Havre de Grace, Md.</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <b>170X</b>		(a) <i>Carcinoma Mammary Gland 2 yrs.</i>	
Antecedent cause(s) <b>50</b>		(b) <i>General Circumstances 6 mos.</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>Caustex</b>		(c) <i>Caustex</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <b>no surgery</b>		19b. MAJOR FINDINGS OF OPERATION <b>X-ray &amp; Radium</b>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE <b>(Specify)</b>		PLACE (Home, farm, factory, street, of office bldg., etc.) <b>St. James</b>	(CITY OR TOWN) <b>(CITY OR TOWN)</b>
TIME (Month) (Day) (Year) (Hour) OF INJURY <b>m.</b>		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <b>ADDRESS</b>
22. I hereby certify that I attended the deceased from <b>May 1949</b> , to <b>April 3, 1951</b> , that I last saw the deceased alive on <b>Apr. 3, 1951</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Harold &amp; Foley M.S. Havre de Grace Md.</b>		DATE SIGNED <b>7/3/51.</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE <b>4/6/51</b>	NAME OF CEMETERY OR CREMATORIAL <b>St. James</b>
LOCATION (City, town, or county) <b>Havre de Grace, Md.</b>		(State)	
DATE REC'D BY LOCAL REG. <b>Apr. 5/1951</b>		REGISTRAR'S SIGNATURE <b>A. L. Lewis, M.D.</b>	24. FUNERAL DIRECTOR ADDRESS <b>Pennington &amp; Son, Havre de Grace, Md.</b>



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3813

## CERTIFICATE OF DEATH

Reg. Dist. No. 180

1. PLACE OF DEATH COUNTY		<i>Hayford</i> MARYLAND	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)	
		<i>Leppa</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			

2. USUAL RESIDENCE (HOME) OF DECEASED STATE		COUNTY	
<i>Maryland</i>		<i>Hayford</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN			
STREET ADDRESS		<i>Leppa</i> (If rural give location)	

3. NAME OF DECEASED (Type or Print)	(First) <i>John</i>	(Middle) <i>Robert</i>	(Last) <i>Duval</i>	4. DATE OF DEATH <i>April 18 1951</i>	(Month) <i>April</i>	(Day) <i>18</i>	(Year) <i>1951</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>Nov. 23, 1869</i>	9. AGE last birthday <i>81</i>	10. If under 1 year Months yrs.	11. If under 24 hrs. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>owner</i>	11. BIRTHPLACE (State or foreign country) <i>Hayford Co Md</i>	12. CITIZEN OF WHAT COUNTRY <i>America</i>			
13. FATHER'S NAME <i>Caleb Duval</i>		14. MOTHER'S MAIDEN NAME <i>Mary Hyde</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mrs Virginia Duval, Catonsville Md</i>				
18. MEDICAL CERTIFICATION							

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause <i>Coronary embolism</i>	(a) _____	INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>
416X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <i>Rheumatic heart disease with</i>	(b) _____	sev. years.
95b stating the underlying cause last <i>Congestive heart failure</i>	(c) _____	

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
------------------------	----------------------------------	--------------

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
-------------------------------------	-----------	---	----------------	----------	---------

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
--	----	--	-----------------------

22. I hereby certify that I attended the deceased from *April 14 1951*, to *Same*, 19....., that I last saw the deceased alive on *April 14 1951*, and that death occurred at *3:45 P.M.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*John F. Nogueira, M.D.**4-18-51*

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <i>Apr. 21 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>St Mary's</i>	LOCATION (City, town, or county) <i>Emmorton, Hayford Md</i>	(State)
--	-------------------------------------	---	---	---------

DATE REC'D BY LOCAL REG.	REGISTRATION'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
--------------------------	--------------------------	----------------------	---------

*April 21 1951 Marie M. Mondale Howard R. McCarren, Sole**Abingdon Md 100105*

*RECEIVED*

APR 24 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3814

2411 N. Charles Street, Baltimore

Reg. Dist. No. 182

## CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <i>Surfside</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Forest Hill</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Forest Hill Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Rural</i>		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print)	(First) <i>Charles</i>	(Middle) <i>Sidney</i>	(Last) <i>Emerson</i>
4. DATE OF DEATH <i>April 26</i>	(Month) <i>1951</i>	(Day) <i>9 Mo.</i>	(Year)
5. SEX <i>M</i>	6. COLOR OR RACE <i>A</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>Aug 11/50</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>C</i>	
11. BIRTHPLACE (State or foreign country) <i>Forest Hill Md</i>		12. CITIZEN OF WHAT COUNTRY <i>X S</i>	
13. FATHER'S NAME <i>Sidney Emerson</i>		14. MOTHER'S MAIDEN NAME <i>South Sefton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>157a</i>		16. SOCIAL SECURITY NO. <i>157a</i>	
17. INFORMANT AND ADDRESS <i>Sidney Emerson</i>		18. MEDICAL CERTIFICATION <i>Hydrocephalus</i>	
INTERVAL BETWEEN ONSET AND DEATH <i>Life</i>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>752x</i> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>157a</i>			
(a) <i>Hydrocephalus</i>			
(b) _____			
(c) _____			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		(STATE)	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? While at Work <input type="checkbox"/> At work <input type="checkbox"/>
22. I hereby certify that I attended the deceased from <i>5/20/51</i> , 1950, to <i>April 26, 1951</i> , that I last saw the deceased alive on <i>April 15</i> , 1951, and that death occurred at <i>9A</i> m., from the causes and on the date stated above. SIGNATURE <i>Terrell C Palmer MD</i> ADDRESS <i>Bethel Md</i> DATE SIGNED <i>4/26/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>April 28/51</i>	
NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) <i>Rugby Cemetery</i> <i>Rugby Virginia Va</i>		(State)	
DATE REC'D BY LOCAL REG. # <i>4/27-51</i>		REGISTRAR'S SIGNATURE <i>Terrell Palmer</i>	
24. FUNERAL DIRECTOR ADDRESS <i>Joseph T. Foster Bellair Md</i>			
108040273405			

RECEIVED

APR 30 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

3815  
1811. PLACE OF DEATH:  
COUNTY

Harford

MARYLAND

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)

TOWN

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESSLENGTH OF STAY  
(in this place)

Rural Havre de Grace Life

2. USUAL RESIDENCE (HOME) OF DECEASED:  
STATE

Md.

COUNTY

Harford

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Rural Havre de Grace

(If rural, give location)

STREET  
ADDRESS3. NAME OF  
DECEASED  
(Type or Print)

(First)

Winner

(Middle)

Haines

(Last)

Apr. 22

1951

## 4. SEX

Female

## 5. COLOR OR RACE

white

6. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

Married

7. KIND OF BUSINESS OR  
INDUSTRY

Home

## 8. DATE OF BIRTH

Oct. 1, 1877

73

9. AGE last birthday  
yrs.If under  
Months1 year  
DaysIf under 24 hrs.  
Hours

Min.

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House wife

## 11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT  
COUNTRY

U.S.A.

## 13. FATHER'S NAME

Isaac C. Coale

## 14. MOTHER'S MAIDEN NAME

Mary Frances De Laney

15. WAS DECASSED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)

No

## 16. SOCIAL SECURITY NO.

—

## 17. INFORMANT AND ADDRESS

Mr. S. Walter Haines

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) *Carcinoma sigmoid & Colon 2 yrs*

153X Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) *General carcinomatosis*

46e

(c) *Cachexia*

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN  
ONSET AND DEATH21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at Work  At work 

HOW DID INJURY OCCUR?

## 20. AUTOPSY?

Yes  No 22. I hereby certify that I attended the deceased from 3/11, 1947, to 4/22, 1951, that I last saw the deceasedalive on 4/22, 1951, and that death occurred at 12:13 a.m. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

## DATE

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial

Apr. 24, 1951

Rock Run

Harford Co.

Md.

DATE REC'D BY LOCAL REG.

APR. 23, 1951

REG. NO.

REG. NO.

24. FUNERAL DIRECTOR

ADDRESS

Reg. No.

REG. NO.

REG. NO.

REG. NO.

REG. NO.

REG. NO.

RECEIVED  
APR 25 1951  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3816

## CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE			
<i>Harford</i>		MARYLAND <i>Maryland</i>			
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)			
TOWN <i>Whiteford, Rural</i>		19 yrs			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET (If rural, give location) ADDRESS			
3. NAME OF DECEASED (Type or Print)		(First) <i>Ella</i>	(Middle) <i>BELLE</i>		
		(Last) <i>HALE</i>	4. DATE OF DEATH <i>April 24 - 1951</i>		
5. SEX		6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>widow</i>		
Female		10b. KIND OF BUSINESS OR INDUSTRY	8. DATE OF BIRTH <i>March 23, 1876</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Grayson Co., Va.</i>	9. AGE last birthday If under 1 year Months Days Hours Min.		
<i>Housewife</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>			
13. FATHER'S NAME <i>John K. Hackler</i>		14. MOTHER'S MAIDEN NAME <i>Evelyn Custer</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.			
(If yes, give war or dates of service)		17. INFORMANT AND ADDRESS <i>Mrs. Martin Roberts, Street, Md.</i>			
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <i>420.1</i>		(a) <i>Coronary Thrombosis</i>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause <i>940</i>		(b) <i>Gen. Anterior Sclerosis</i>			
		(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) <i>(CITY OR TOWN)</i>	(COUNTY) <i>(COUNTY)</i>	(STATE) <i>(STATE)</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify, that I attended the deceased from ..... , 19 <i>45</i> , to <i>April 27, 1951</i> , that I last saw the deceased alive on <i>April 14, 1951</i> , and that death occurred at <i>10:30</i> p.m., from the causes and on the date stated above.				SIGNATURE <i>Donald G. Hunt, M.D.</i> (Degree or title) <i>ADDRESS</i> DATE SIGNED <i>4/25/51</i>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <i>Apr. 28, 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Tabernacle Cemetery, Whiteford, Md.</i>	LOCATION (City, town, or county) <i>Whiteford, Md.</i>	(State) <i>(State)</i>
DATE REC'D BY LOCAL REG. <i>4/25/51</i>		REGISTRAR'S SIGNATURE <i>Priscilla Lowood</i>	24. FUNERAL DIRECTOR <i>Robert P. Starkie</i>	ADDRESS <i>Delta, Pa.</i>	

RECEIVED

MAY 10 1951

BUREAU, F. B. I.

## MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3817

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
<i>Harford</i>		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)	
TOWN <i>Aberdeen Rural</i>		<i>life</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
<i>Churchville</i>		<i>Churchville</i>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <i>G</i>		(Middle) <i>Hayes</i>	
(Last) <i>Hamilton</i>		(Month) <i>April</i>	
		(Day) <i>4th</i>	
		(Year) <i>1951</i>	
5. SEX		6. COLOR OR RACE	
<i>Male</i>		<i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widow</i>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>William P. Hamilton</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Day</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <i>Mrs Frank Murray, Churchville</i>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) *Mesenteric Thrombosis*INTERVAL BETWEEN  
ONSET AND DEATH

36 hrs

## Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) *Syphilitic - sclerotic CV Disease*

11 yrs

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.*none*

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE(Specify) *No*PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURYINJURY OCCURRED  
While at Work  Not While At Work 

HOW DID INJURY OCCUR?

m.

22. I hereby certify that I attended the deceased from *June*, 19*50*, to *April*, 19*51*, that I last saw the deceased alive on *April 4, 1951*, and that death occurred at *8:15 P.m.*, from the causes and on the date stated above.  
SIGNATURE *Ralph Horky Jr.* (Degree or title) *ADDRESS* *Churchville, Maryland* DATE SIGNED *April 6, 1951*23. BURIAL, CREMATION  
REMOVAL (Specify)DATE REC'D BY LOCAL  
REG. *April 7-1951*DATE REC'D BY LOCAL  
REG. *April 7-1951*DATE THEREOF *4/7/51*NAME OF CEMETERY OR CREMATORIAL *Gunther State Cemetery*LOCATION (City, town, or county) *Churchville Maryland* (State) *MD*REGISTRAR'S SIGNATURE *Helen S. Rivers*24. FUNERAL DIRECTOR *Henry Tarrington and Sons Aberdeen*ADDRESS *10085 Maryland*

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3818

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <u>Harford</u> STATE <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Harford</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town <u>Town Havre de Grace</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Havre de Grace</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>128 Bloomsbury</u> (If rural, give location)			
3. NAME OF DECEASED (Type or Print)	(First) <u>William</u>	(Middle) <u>Oliver</u>	(Last) <u>Hankin</u>		
4. DATE OF DEATH	(Month) <u>4/27/51</u>	(Day) <u>19</u>	(Year)		
5. SEX	6. COLOR OR RACE <u>Male</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/20/1894</u>		
9. AGE last birthday If under 1 year Months <u>57</u> Days <u>2</u>	10. KIND OF BUSINESS OR INDUSTRY <u>Foreman Automotive Test Division, Proving Ground</u>	11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Edward Hankin</u>	14. MOTHER'S MAIDEN NAME <u>Elizabeth Foster</u>	15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT AND ADDRESS <u>Mary E. Hankin, Havre de Grace</u>	18. MEDICAL CERTIFICATION  <i>Acute Pulmonary Edema Cerebral Hemorrhage - Malignant hypertension</i>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  <i>331x Immediate cause (a) Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) 83a</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs. 1 day 10 years</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)		(COUNTY) (STATE)
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
m.					
22. I hereby certify that I attended the deceased from <u>April 27</u> , 19 <u>51</u> , to <u>April 27</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>April 27</u> , 19 <u>51</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>John W. Oliver M.D.</u> ADDRESS <u>Havre de Grace Md.</u> DATE SIGNED <u>4/28/51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>4/30/51</u>	NAME OF CEMETERY OR CREMATORIUM <u>Angel Hill</u>	LOCATION (City, town, or county) (State) <u>Havre de Grace, Md.</u>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Apr. 29-1951</u>	24. FUNERAL DIRECTOR <u>A. L. Lewis M.D.</u>		ADDRESS <u>Dwight Son, Havre de Grace, Md.</u>		

**RECEIVED**

MAY 2 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 182

1. PLACE OF DEATH. COUNTY <u>Harford</u>			2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Md</u> COUNTY <u>Harford</u>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Madonna</u> LENGTH OF STAY <u>in this place</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Madonna</u> (Rural) STREET ADDRESS		
3. NAME OF DECEASED (Type or Print) <u>Walter Holmes</u>			4. DATE OF DEATH <u>April 15 1951</u>		
5. SEX <u>Male</u> 6. COLOR OR RACE <u>white</u>			7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tenant Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Agricultural Farming</u>		
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>		
13. FATHER'S NAME <u>John Henry Holmes</u>			14. MOTHER'S MAIDEN NAME <u>Emma Folks</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Mrs. Ada Holmes, Street, Md.</u>			18. MEDICAL CERTIFICATION		
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause <u>Arteriosclerotic CV disease</u>  4/22/1 Antecedent cause(s) Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last 93d (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE <u>Lerold C Palmer</u>		(Degree or title) <u>Deputy Medical Examiner</u>		ADDRESS <u>Hager Co. Bel-Air Md 4/1/51</u>	
DATE SIGNED <u>4/1/51</u>					
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>April 17 1951</u>		NAME OF CEMETERY OR CREMATORIAL <u>Bel-Air Mem. Gardens</u>	
DATE REC'D BY LOCAL REG. <u>4/16/51</u>		REGISTRAR'S SIGNATURE <u>Francesca Towood</u>		LOCATION (City, town, or county) <u>Bel-Air, Md.</u>	
				24. FUNERAL DIRECTOR <u>Martin G. Kurtz, Jarrettsville, Md.</u>	
				ADDRESS <u>100 105</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 20 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3820

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## 1. PLACE OF DEATH.

COUNTY  
Harford

Maryland

MARYLAND

CITY (If outside corporate limits, write RURAL and  
OR give nearest town)LENGTH OF STAY  
(in this place)  
50 yrs.

TOWN Havre de Grace

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE  
MarylandCOUNTY  
HarfordCITY (If outside corporate limits, write RURAL and give nearest town)  
OR

TOWN Havre de Grace

STREET  
(If rural, give location)  
ADDRESS 413 N. Stokes3. NAME OF  
DECEASED  
(Type or Print)(First)  
Bernice M.

(Middle)

Hopper

(Last)

4. DATE  
OF  
DEATH(Month)  
4/27/51(Day)  
19

## 5. SEX

Female

6. COLOR OR RACE  
White7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) Widow8. DATE OF BIRTH  
Unknown9. AGE last birthday  
Abt. 82 yrs.If under 1 year  
MonthsIf under 24 hrs.  
Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House Wife

10b. KIND OF BUSINESS OR  
INDUSTRY11. BIRTHPLACE (State or foreign country)  
Washington D.C.12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

## 13. FATHER'S NAME

Unlnown

## 14. MOTHER'S MAIDEN NAME

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)

no

16. SOCIAL SECURITY NO.  
Unknown17. INFORMANT AND ADDRESS  
Mae Jones, Temple Trailer Village, Alexandria

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

V  
INTERVAL BETWEEN  
ONSET AND DEATH

## Immediate cause

(a) -

(b) -

(c) -

592X Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b) -

(c) -

Cardiac Insufficiency  
Chronic nephritis (Disses)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF INJURY

m.

INJURY OCCURRED  
While at Work  Not While At work 

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-3, 1951, to 4-27, 1951, that I last saw the deceased

alive on 4-27, 1951, and that death occurred at 7 P.M., from the causes and on the date stated above.  
SIGNATURE *R. Lewis, Jr.* ADDRESS *Havre de Grace, Md.* DATE SIGNED *5-3-51*23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial

5/2/51

Angel Hill

Havre de Grace, Md.

DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

24. FUNERAL DIRECTOR

Pomington &amp; Son, Havre de Grace, Md.

ADDRESS

REG. DATE REC'D BY LOCAL REG.

REG. DATE REC'D BY LOCAL REG.

ADDRESS

RECEIVED  
MAY 4 1951  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3821

Item #9 on:

WW

FD No. G 132 MAY 2 1951

## CERTIFICATE OF DEATH

Reg. Dist. No. 82

1. PLACE OF DEATH COUNTY <i>Harford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i>				
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Bell Air</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Bell Air</i>				
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print)	(First) <i>Dorothy</i>	(Middle) <i>Elizabeth</i>	(Last) <i>Howard James</i>			
4. DATE OF DEATH	(Month) <i>April</i>	(Day) <i>16</i>	(Year) <i>1951</i>			
5. SEX	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>M</i>	8. DATE OF BIRTH <i>Mar 5-1916</i>			
9. AGE last birthday Months Years	10. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Bell Air Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>KS</i>			
13. FATHER'S NAME <i>George H Howard</i>	14. MOTHER'S MAIDEN NAME <i>Patricia Leaguer</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <i>R Bruce James Bell Air Md.</i>				
18. MEDICAL CERTIFICATION						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
Immediate cause (a) <b>CARDIO-RESPIRATORY FAILURE</b> Antecedent cause(s) (b) <b>SARCOMATOSIS</b> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)						
Primary site: Retroperitoneal - sacral area of abdomen (5/2/51 d/c)						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				
21. ACCIDENT SUICIDE HOMICIDE	(Specify) <i>None</i>	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)	
TIME (Month) OF INJURY	(Day) None	(Year) m. h. m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>OCT</b> , 19 <b>51</b> , to <b>16 Nov</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>16 Nov</b> , 19 <b>51</b> , and that death occurred at <b>4:05 P</b> .m., from the causes and on the date stated above.						
SIGNATURE <i>R. J. Adcock M.D.</i>	(Degree or title)		ADDRESS <i>Bell Air Md</i>	DATE SIGNED <i>17 Jun 51</i>		
23. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>April 18/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Bethel Memorial</i>	LOCATION (City, town, or county) <i>Bell Air</i>	(State) <i>Harford Co</i>		
DATE REC'D BY LOCAL REG. <i>4/17/51</i>	REGISTRAR'S SIGNATURE <i>McAllister</i>	24. FUNERAL DIRECTOR <i>J. T. Justice</i>	ADDRESS <i>Bell Air Md</i>			

RECEIVED  
DEC 19 1951  
BUREAU U. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

I. PLACE OF DEATH COUNTY <b>HARFORD</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b>		COUNTY <b>HARFORD</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>HAURE de GRACE</b>		LENGTH OF STAY (in this place) <b>24 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Churchville</b>		(If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>HARFORD MEMORIAL Hosp.</b>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <b>M. Elizabeth</b>		(First)	(Middle)	(Last)	4. DATE OF DEATH <b>April 18</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>1-4-91</b>	9. AGE last birthday <b>60</b> yrs.	If under 1 year Months	If under 24 hrs. Days	(Year) Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Rembold</b>		14. MOTHER'S M AIDEN NAME <b>Matilda SIEGMAN</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS <b>Mrs John Oakley Magnolia, Md</b>		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <b>154X</b>		(a) <i>Carcinoma of Rectum</i>					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <b>46d</b>		(b) _____					
		(c) _____					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <b>4-2-51</b>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of Rectum</i>		20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) <b>(CITY OR TOWN)</b>		(COUNTY) <b>(COUNTY)</b>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>3-26-1951</b> , to <b>4-18-1951</b> , that I last saw the deceased alive on <b>4-18-1951</b> , and that death occurred at <b>11:00 P.m.</b> , from the causes and on the date stated above.							
SIGNATURE <i>John A. Sarno, M.D.</i>		(Degree or title) <b>Specalist</b>		ADDRESS <b>Harford Memorial Hosp. Md 4-1851</b>			
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>Apr. 25, 1951</b>		NAME OF CEMETERY OR CREMATORIAL <b>Perryman's Hospital</b>		LOCATION (City, town, or county) <b>(State)</b>	
DATE REC'D BY LOCAL <b>Apr. 24-1951</b>		REGISTRAR'S SIGNATURE <b>G. L. Lewis m.d.</b>		24. FUNERAL DIRECTOR <b>Howard K. McComas &amp; Son</b>		ADDRESS <b>Abingdon Maryland</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3823

## CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH-  
CITY  
TOWN

Hayford

MARYLAND

CITY (If outside corporate limits, write RURAL and  
give nearest town)LENGTH OF STAY  
(in this place)

Perryman.

54 yrs.

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Residence -

3. NAME OF  
DECEASED  
(Type or Print)(First)  
Sarah(Middle)  
Katharine2. USUAL RESIDENCE (HOME) OF DECEASED-  
STATE

Maryland

COUNTY

Hayford

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

Perryman.

(If rural, give location)

STREET  
ADDRESS

residence.

4. DATE  
OF  
DEATH

Lee

Lee

April

4

1957

## 5. SEX

Female

6. COLOR OR RACE  
white7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify) Widowed8. DATE OF BIRTH  
Oct 30 18639. AGE last birthday  
87If under 1 year  
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

some wife

10b. KIND OF BUSINESS OR  
INDUSTRY

own time

11. BIRTHPLACE (State or foreign country)  
Hayford County Md.12. CITIZEN OF WHAT  
COUNTRY? USA

## 13. FATHER'S NAME

Lawrence Kehoe

## 14. MOTHER'S MAIDEN NAME

Sarah Toal

15. WAS DECREASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of  
service)

No

16. SOCIAL SECURITY NO.  
none17. INFORMANT AND ADDRESS  
son - Harry Lee Perryman18. MEDICAL CERTIFICATION  
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATHINTERVAL BETWEEN  
ONSET AND DEATHImmediate cause  
420.1

(a) Cerebral anoxemia

5 minutes

Antecedent cause(s)  
94aDiseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last

(b) coronary occlusion

1 hour

(c) malignant hypertension - arteriosclerosis

20 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 21. ACCIDENT  
SUICIDE  
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,  
OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
OF  
INJURYINJURY OCCURRED  
While at Work At work

HOW DID INJURY OCCUR?

## 22. I hereby certify that I attended the deceased from April 4, 1957, to April 4, 1957, that I last saw the deceased

alive on April 4, 1957, and that death occurred at 6:15 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

Burial

Apr. 7, 1957

Specialty

Perryman, Hayford Md

Cremation

Local Reg.

REG.

REG.

REG.

REG.

Date Rec'd by Local

REG.

REG.

REG.

REG.

Registrar's Signature

REG.

REG.

REG.

REG.

Date

REG.

REG.

REG.

REG.

RECEIVED

APR 16 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

3824

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. / 82

1. PLACE OF DEATH CITY OR TOWN HARFORD		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland		COUNTY HARFORD	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN Magnolia	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HARFORD COURTESY & DRUGS				STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) JOSEPH	(Middle) THOMAS	(Last) REIGHT	4. DATE OF DEATH APRIL 13 1951	(Month)	(Day)	(Year)
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept 5, 1861	9. AGE last birthday 90	If under 1 year Months	1 year Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	11. BIRTHPLACE (State or foreign country) Harford Co Md	12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Joseph Reight		14. MOTHER'S MAIDEN NAME Luskroom					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS Mosby Mc Kerney Magnolia Md				

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

CORONARY OCCLUSION

INTERVAL BETWEEN  
ONSET AND DEATH

4 YEARS

## Immediate cause

(a)

420.1

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause  
stating the underlying cause last

93d

HYPERTENSIVE CARDIOVASCULAR DISEASE

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
INJURY					
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work	HOW DID INJURY OCCUR? Not While At work
OF INJURY	-	m.	-	<input type="checkbox"/>	<input type="checkbox"/>

22. I hereby certify that I attended the deceased from SEPT. 1947, to APRIL 1951, that I last saw the deceased

alive on 4/8 1951, and that death occurred at 5 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED  
4/15/51

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Apr 16 1951	NAME OF CEMETERY OR CREMATORIAL Cottingham	LOCATION (City, town, or county) Abingdon Bayard Md
DATE REC'D BY LOCAL REG. 4/16/51	REGISTRAR'S SIGNATURE Priscilla Fowrad	24. FUNERAL DIRECTOR Abingdon Bayard	ADDRESS Abingdon Bayard 510506

25

RECEIVED  
APR 20 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

3825  
181

1. PLACE OF DEATH COUNTY <b>Harford</b>		MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>		COUNTY <b>Harford</b>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Aberdeen</b>		LENGTH OF STAY (In this place) <b>14 yrs.</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Aberdeen</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <b>15 E. Bel Air Ave.</b>		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <b>Robert</b>	(Middle) <b>Seneca</b>	(Last) <b>Myers</b>	4. DATE OF DEATH <b>4/8/51</b>	(Month) <b>4</b> (Day) <b>19</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1/17/1881</b>	9. AGE last birthday <b>70</b>	If under Months <b>2</b> yrs. Days <b>22</b> Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired R.R. Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. &amp; Ohio R.R.</b>	11. BIRTHPLACE (State or foreign country) <b>Hayre de Grace</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>William A. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Georgiana Lawder</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT AND ADDRESS <b>Beulah R. Myers, Aberdeen, Md. (Wife)</b>		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **CARDIAC FAILURE**

420.0 Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last(b) **CORONARY OCCLUSION (THROMBOSIS)**

2 YEARS

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.(c) **ARTERIOSCLEROTIC HEART DISEASE**

10 YEARS

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes  No 

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) OF INJURY	(Day)	(Year)	(Hour)	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **April 10, 1949**, to **April 8, 1951**, that I last saw the deceasedalive on **April 8, 1951**, and that death occurred at **6:30 P.m.** from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**Brown McDonald, M.D.****4-10-57**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>4/11/51</b>	NAME OF CEMETERY OR CREMATORIUM <b>Angel Hill</b>	LOCATION (City, town, or county) <b>Havre de Grace, Md.</b>	(State)
DATE REC'D BY LOCAL REG.	REG.	REG.	FUNERAL DIRECTOR <b>Pennington &amp; Son</b>	ADDRESS <b>Havre de Grace, Md.</b>
DATE REC'D BY LOCAL REG.	REG.	REG.	REG.	REG.

RECEIVED  
APR 12 1968  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3826

## CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH COUNTY <b>Harford</b>		MARYLAND Maryland	LENGTH OF STAY (in this place) <b>67 yrs.</b>	2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b>		COUNTY <b>Harford</b>
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)				
TOWN <b>Havre de Grace</b>		TOWN <b>Havre de Grace, Md.</b>				
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <b>Maryland, Apts.</b>				
3. NAME OF DECEASED (Type or Print)	(First) <b>Stephen</b>	(Middle) <b>Clyde</b>	(Last) <b>Myers</b>	4. DATE OF DEATH <b>4/22/51</b>	(Month) <b>4</b>	(Day) <b>19</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>3/17/1884</b>	9. AGE last birthday <b>67</b>	If under 1 year Months <b>4</b>	If under 24 hrs. Days <b>4</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mergler Elec. Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Havre de Grace</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George T. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Russell</b>				
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT AND ADDRESS <b>John Myers, Havre de Grace, Md.</b>			
18. MEDICAL CERTIFICATION						
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						
<p>Immediate cause      (a) <i>Coronary Thrombosis</i>  <i>Arterial Dolorous</i></p> <p>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a      (b) <i>Hypertension</i></p>						
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work    At work	HOW DID INJURY OCCUR? DATE SIGNED			
22. I hereby certify that I attended the deceased from <i>Jan 10, 1951</i> , to <i>April 22, 1951</i> , that I last saw the deceased alive on <i>April 22, 1951</i> , and that death occurred at <i>60</i> a.m., from the causes and on the date stated above.						
SIGNATURE: <i>Charles D. Foley MD</i>		ADDRESS: <i>400 W. Maryland Ave</i>				
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>4/25/51</b>	NAME OF CEMETERY OR CREMATORIAL <b>Angel Hill</b>	LOCATION (City, town, or county) <b>Havre de Grace, Md.</b>		
DATE REC'D BY LOCAL REG. <i>Apr. 25-1951</i>		24. FUNERAL DIRECTOR ADDRESS <i>Pemberton &amp; Son, Havre de Grace, Md.</i>				
REG. <i>Apr. 25-1951</i>		REG. <i>Apr. 25-1951</i>				

RECEIVED  
APR 30 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3827

Reg. Dist. No. 181

## CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Harford MARYLAND			2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pennsylvania COUNTY Armstrong		
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) TOWN Aberdeen (in this place) HOSPITAL OR 2151-1 US Army Hospital INSTITUTION OR Aberdeen Proving Ground STREET ADDRESS			CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kittanning STREET ADDRESS R.F.D. #3 (If rural, give location)		
3. NAME OF DECEASED (Type or Print) INFANT FEMALE			4. DATE OF DEATH April 13 1951		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, DIVORCED, WIDOWED (Specify) Single	8. DATE OF BIRTH 13 April 1951	9. AGE last birthday yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Theodore Olinger			14. MOTHER'S MAIDEN NAME Sara Jane Swigart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT AND ADDRESS Mother	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) Prematurity, craniorachischisis Antecedent cause(s) (b) Polyhydramnios Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
1 hour					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY			(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	While at m. Work	Not While At work	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 13 April, 1951 to 13 April, 1951, that I last saw the deceased alive on 13 April, 1951, and that death occurred at 3:00 P.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
Robert W. Collopy M.D. 2151-1 US Army Hosp, Aberdeen PrGr, Md. 5/26/51					
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF April 17, 1951	NAME OF CEMETERY OR CREMATORIAL Aberdeen Post Cemetery		LOCATION (City, town, or county) (State) Aberdeen Proving Ground, Md.	
DATE REC'D BY LOCAL REG.	REG. 26-1951	REGISTRAR'S SIGNATURE Nellie H. Riley	24. FUNERAL DIRECTOR ADDRESS t/ HENRY TARRING & SONS, Aberdeen, Md.		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A5



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3828

## CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH COUNTY		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Baltimore Rural		Harford	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		R70 #2 - Harford Furnace		STREET ADDRESS		(If rural, give location)		Harford Furnace.	
3. NAME OF DECEASED (Type or Print)		(First) Mary	(Middle) M.	(Last) Oliver	4. DATE OF DEATH		(Month) 4	(Day) 13	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY	
Female	White	Widowed	Jan. 26th 1863	88 yrs.	Home	Maryland	USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. INFORMANT AND ADDRESS		14. MOTHER'S MAIDEN NAME					
Housewife		Edward St. Oliver - 2827 Overland Ave., Bello.		Eva Catherine Berkley.					
13. FATHER'S NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.					
John Jacob Stumpfner				—					
17. MEDICAL CERTIFICATION		18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH					
Immediate cause		(a) coronary occlusion		2 months					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) generalized arterial sclerosis		Years					
920.1 94a		(c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.									
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?					
TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> HOW DID INJURY OCCUR?					
m.									
22. I hereby certify that I attended the deceased from Feb. 10, 1951, to April 13, 1951, that I last saw the deceased alive on April 13, 1951, and that death occurred at 12:15 P.m., from the causes and on the date stated above. SIGNATURE		(Degree or title)		ADDRESS					
T. O. Hodson		m.d.		Edgewood					
DATE SIGNED		4-14-51							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county)					
Burial		4/16/51		St. Mary's Epic. Cemetery, Lusby, Harford Co., Maryland					
(State)									
DATE REC'D BY LOCAL REG.		RECEIVER'S SIGNATURE		24. FUNERAL DIRECTOR					
Apr. 14-51		Helen H. Riley		Henry Tarrington Sons, a business					
				Maryland.					

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
FEB 17 1951  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

3829

Reg. Dist. No. 185

1. PLACE OF DEATH COUNTY <i>Harford</i>		MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>New Jersey</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Name de Grace</i>		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Belmar</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial Hospital</i>		STREET ADDRESS <i>1734 River Road</i>	(If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>W</i>	(Middle) <i>b</i>	(Last) <i>Pierson</i>	4. DATE OF DEATH <i>April 4 1957</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>June 28 1865</i>	9. AGE last birthday <i>85</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Vice Pres.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>New York Life Ins.</i>	11. BIRTHPLACE (State or foreign country) <i>New Jersey</i>	12. CITIZEN OF WHAT COUNTRY? <i>A.S.A.</i>
13. FATHER'S NAME <i>John L. Pierson</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Van Kirk</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Rose L. Pierson</i>		
17. INFORMANT				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause  
*420.1*

(a)

*Coronary Occlusion*

INTERVAL BETWEEN  
ONSET AND DEATH

*none*

Antecedent cause(s)

Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last  
*61*

(b)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not  
related to the disease or condition causing death.

*Diabetes Mellitus*

*15 years*

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes  No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Name, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry  thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined ..

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>4/7/51</i>	NAME OF CEMETERY OR CREMATORIUM <i>Evergreen Cemetery Elizabeth New Jersey</i>	LOCATION (City, town, or county) (State) <i>Elizabeth New Jersey</i>
DATE REC'D BY LOCAL REC'D <i>Apr. 4 1951</i>	REGISTRIES SIGNATURE <i>A. L. Lewis m.d.</i>	24. FUNERAL DIRECTOR ADDRESS <i>Washington &amp; Son Hampton Roads Hampton, Va. Md. 290 736</i>	

MARGIN RESERVED FOR BINDING

260X

VS. A15A T

PLEASE WRITE PLAINLY; WITH UNFADING INK. Supply every item of information carefully. The correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

3830

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....

RURAL, EDGEWOOD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

4 YEARS

Hospital, institution, or street address where death occurred:

Willoughby Beach Road

How long in hospital or institution?.....

## 3. (a) FULL NAME

DAVID PODRUCHNY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife

Jessie M. Podruchny

7. Birth date of deceased (mo., day, yr.)

Oct 11<sup>th</sup> 1908

6.(c) If alive, give age.....

years

8. AGE:

Years  
42

Months

Days

It less than one day

hrs. ..... min.

9. Birthplace.....

Yale Va.

(Town, county, and state)

10. Usual occupation.....

Painter

11. Industry or business

Bethlehem Steel

12. Name.....

Thomas Podruchny

13. Birthplace

Russia

14. Maiden name.....

Viola Patank

Russia

16. Informant.....

Mrs. Jessie M. Podruchny

Address

Willoughby Beach Rd Edgewood

Burial Date thereof.....

4/12/51

(month) (day) (year)

17. (Burial, cremation, or removal—Which?)

Holy Trinity Cemetery

Balto. Md.

Location.....

Wm Cook Inc.

18. Funeral director.....

1217 St. Paul St.

Address.....

APR 11 1951

(Date rec'd by registrar)

W. W. Bednar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md

County.....

Balto

City or town.....

Edgewood

Street No.....

Willoughby Beach Rd

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

213-07-4318

## MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

9 APRIL

19.51 at 11:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 APRIL

19.51 to 9 APRIL 19.51

and that I last saw him alive on.....

6 APRIL

19.51

Immediate cause of death.....

INTRACRANIAL

TUMOR, TYPE UNKNOWN

DURATION

18 MONTHS

Due to.....

UNKNOWN

Duo to.....

—

Other conditions.....

SEVERE HYPERTENSION

237X

(Include pregnancy within 3 months of death)

57d

Major findings of operations.....

—

Date of op.....

Autopsy results.....

—

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work? 564336

23. SIGNATURE.....

Dr. Stewart Jr. M.D.

M. D. or other

Address.....

EDGEGOOD, MD.

Date signed 9 APRIL 51

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

3831

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I. PLACE OF DEATH. COUNTY <i>Hartford</i>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>Md</i>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Thomas Run</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>(Thomas Run) Oldfield</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)	(First) <i>Margaret</i>	(Middle)	(Last) <i>RUMSEY</i>		
4. DATE OF DEATH <i>April 23</i>	(Month) <i>April</i>	(Day) <i>23</i>	(Year) <i>1951</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>Col</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 15/1869</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hause Wife</i>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>82</i>	If under 1 year Months Days Hours Min.		
11. FATHER'S NAME <i>Sy More Collins</i>	12. CITIZEN OF WHAT COUNTRY? <i>YS</i>	13. MOTHER'S MAIDEN NAME <i>Harriett Collins</i>	14. INFORMANT AND ADDRESS <i>Mrs Hanna born Boarding Md</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>93d</i>	16. SOCIAL SECURITY NO.	17. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>18</i>			
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <i>443X</i> Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>93d</i>					
(a) ... <i>Chr. Myocardial Disease</i> (b) ... <i>Chr hypertension Cardo-Vascular</i> disease — <i>10 yrs.</i> (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION				
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	(CITY OR TOWN) <i>(CITY OR TOWN)</i>	(COUNTY) <i>(COUNTY)</i>	(STATE) <i>(STATE)</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <i>April 21, 1951</i> , to <i>April 23 1951</i> , that I last saw the deceased alive on <i>April 22, 1951</i> , and that death occurred at ..... m., from the causes and on the date stated above. SIGNATURE <i>Wesford P. Hudson, M.D.</i> ADDRESS <i>7 East Hill Rd</i> DATE SIGNED <i>4/23/51</i>					
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE THEREOF <i>April 26/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Clark's Chapel</i>	LOCATION (City, town, or county) <i>Gibson Hartford Co, Md</i>	(State) <i>(State)</i>	
DATE REC'D BY LOCAL REG. <i>4/24/51</i>	REGISTRAR'S SIGNATURE <i>Wilma Soword</i>	24. FUNERAL DIRECTOR <i>Joseph L. Foster Bellair Md</i>			

RECEIVED  
APR 25 1951  
BUREAU U.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

3832

## CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH: COUNTY <i>Garfield</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>MD</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Taylor</i>		LENGTH OF STAY (in this place) <i>39 yrs</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Taylor</i>	
3. NAME OF DECEASED (First) <i>George</i> (Middle) <i>Edward</i> (Last) <i>Walker</i> (Type or Print)		4. DATE OF DEATH <i>Apr 18 1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWER, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Dec 10 1888</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Journal Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Betheldege Hospital</i>		12. CITIZEN OF WHAT COUNTRY <i>US</i>	
13. FATHER'S NAME <i>Abrraham B Walker</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ellen Brookhart</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <i>Mrs Florence A Walker</i>		18. MEDICAL CERTIFICATION <i>Fallston Rd</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <i>Coronary Thrombosis</i>			
Antecedent cause(s) (b) <i>Arteriosclerotic Heart Disease</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>Generalized Arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>			
(?)			
5 years.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> m. <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>April 18, 1951</i> , to <i>April 18, 1951</i> , that I last saw the deceased alive on <i>April 18, 1951</i> , and that death occurred at <i>11:30 p.m.</i> , from the causes and on the date stated above. SIGNATURE <i>J. James Shumard</i> (Degree or title) <i>ADDRESS</i> <i>Genettsville, Md</i> DATE SIGNED <i>4/19/51</i>			
23. BURIAL Cremation REMOVAL (Specify) <i>Cremated</i>		DATE THEREOF <i>4-21-51</i>	
NAME OF CEMETERY OR CREMATORIUM <i>St James</i>		LOCATION (City, town, or county) <i>Montgomery</i> (State) <i>MD</i>	
DATE REC'D BY LOCAL REG. <i>4/20/51</i>		REGISTRAR'S SIGNATURE <i>Ovisella Lovwood</i>	
24. FUNERAL DIRECTOR <i>Marvin Green</i>		ADDRESS <i>Spokane Street</i>	
		<i>Spokane Street</i>	
		<i>10010</i>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED

APR 25 1951

BUREAU W. S.